Parents/Guardians

Health Services

Entrance into Kindergarten

As you register your child for Kindergarten entrance, we would like you to be aware of the following:

- Minnesota Statute 121A.15 requires all students enrolled in public or private schools to be fully immunized against certain preventable communicable diseases. The attached immunization certificate must be completed and signed by a parent/guardian or physician/healthcare provider. A printed record of immunizations from your child's clinic is acceptable. If you are requesting a non-medical exemption, please use the Student Immunization Form (section 1B) to document your child's status. If you are requesting a medication exemption, please use the Student Immunization Form (section 1A) signed by a health care provider to document your child's status.

- Children entering Kindergarten are generally required to have **five DTaP's** (diphtheria, tetanus, pertussis), **four Polios**, **two MMR's** (measles, mumps, rubella), **two Varicella** (chickenpox), and **three Hepatitis B vaccinations**. Physician/healthcare providers may recommend a Hepatitis A series. Some variations of the schedule may be acceptable.

- **Two Varicella** (chickenpox) vaccinations, or proof (month/year) of chickenpox disease is required for Kindergarten. A physician/healthcare provider signature is needed in the medical exemption section of the Student Immunization Form (section 2) to verify chickenpox disease.

- **These requirements can be waived for children with medical contraindications or parents who's conscientiously held beliefs are opposed to immunizations. If you are requesting an exemption, please use the Student Immunization Form (section 1B) to document your child's status. You must check the box of the immunizations your child is to be exempt from and the form must be notarized.**

- Physical examinations are recommended for all Kindergarten students. Please take the physical examination form with you at the time of the examination for the physician/healthcare provider to complete. Please fill in the information at the top of the form prior to the appointment.

- **This immunization and physical form need to be returned to your child's school by AUGUST 15TH. If the school has not received it by August 15th, you will be contacted by the school nurse. If your child needs medicine at school, additional medication authorization paperwork and a supply of the medication is required. If you have further questions and/or information that you wish to discuss with the school nurse, please feel free to call your child's school.**

Thank you,

St. Cloud Area School District 742 Health Services Department
### Are Your Kids Ready?
**What Minnesota’s Immunization Law Requires**

**Immunization Requirements**
Use this chart as a guide to determine which vaccines are required to enroll in child care, early childhood programs, and school (online, home school, public, or private).

Find the child’s age/grade level and look to see if your child had the number of shots shown by the checkmarks under each vaccine. The table on the back shows the ages when doses are due.

<table>
<thead>
<tr>
<th>Birth through 4 years</th>
<th>Age: 5 through 6 years</th>
<th>Age: 7 through 11 years</th>
<th>Age: 12 years and older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early childhood programs &amp; Child care</td>
<td>For Kindergarten</td>
<td>For 1st through 6th grade</td>
<td>For 7th through 12th grade</td>
</tr>
<tr>
<td><strong>Hepatitis A (Hep A)</strong></td>
<td><strong>Hepatitis B</strong></td>
<td><strong>Hepatitis B</strong></td>
<td><strong>Hepatitis B</strong></td>
</tr>
<tr>
<td></td>
<td>✅ ✅</td>
<td>✅ ✅</td>
<td>✅ ✅</td>
</tr>
<tr>
<td><strong>Hepatitis B (Hep B)</strong></td>
<td><strong>DTaP/DT</strong></td>
<td><strong>DTaP/DT</strong></td>
<td><strong>Tdap</strong> &amp; DTaP series or catch-up series</td>
</tr>
<tr>
<td>✅ ✅</td>
<td>✅ ✅</td>
<td>✅ ✅</td>
<td>✅</td>
</tr>
<tr>
<td><strong>Polio</strong></td>
<td><strong>Polio</strong></td>
<td><strong>Polio</strong></td>
<td><strong>Polio</strong></td>
</tr>
<tr>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td><strong>MMR</strong></td>
<td><strong>MMR</strong></td>
<td><strong>MMR</strong></td>
<td><strong>MMR</strong></td>
</tr>
<tr>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td><strong>Hib</strong></td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td><strong>Pneumococcal</strong></td>
<td><strong>Varicella</strong></td>
<td><strong>Varicella</strong></td>
<td><strong>Varicella</strong></td>
</tr>
<tr>
<td>✅ ✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td><strong>Varicella</strong></td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td><strong>It’s not too late! If your child has fallen behind on their vaccinations, talk to your doctor or clinic to catch them up.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Immunizations recommended but not required:**

**COVID-19**
For all children in an eligible age group

**Influenza**
Annually for all children age 6 months and older

**Rotavirus**
For infants

**Human papillomavirus**
At age 11-12 years

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1. Not required after 24 months.
2. If the child has already had chickenpox disease, varicella shots are not required. If the disease occurred after 2010, the child’s doctor must sign a form confirming disease.
3. First graders who are 6 years old and younger must follow the polio and DTaP/DT schedules for kindergarten.
4. Fifth shot of DTaP not needed if fourth shot was after age 4. Final dose of DTaP on or after age 4.
5. Fourth shot of polio not needed if third shot was after age 4. Final dose of polio on or after age 4.
6. One dose must have been pertussis-containing (i.e., DTaP or Tdap) and one dose must have been given after the fourth birthday. If the first dose in the series was given before age 12 months, then four doses are needed.
7. An alternate two-shot schedule of hepatitis B may also be used for kids age 11 through 15 years.
8. At least one dose must have been given after the fourth birthday. If the third dose was given before the fourth birthday, a fourth dose is needed.
9. One dose of meningococcal ACWY is required beginning at 7th grade. The meningococcal ACWY booster dose is recommended at 16 years and required for 12th grade students.

**Exemptions**
To enroll in child care, early childhood programs, and school in Minnesota, children must show they’ve had these immunizations or file a legal exemption.

Parents may file a medical exemption signed by a health care provider or a non-medical exemption signed by a parent/guardian and notarized.

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Minnesota Department of Health, Immunization Program

ID# 52799 (1/2022)
In accordance with state and local regulations, this form must be signed by a parent or guardian. This signature indicates consent to share immunization information with the school and healthcare providers.

1. **Date:**

2. **Signature:**

   **(Name of Parent or Guardian)**

   **(Date)**

   **Notary Stamp**

   **Notary:**

   **Notary Signature:**

   **Non-medical exemptions must also be signed and stamped by a notary**

   **(Date) (Location of Guardian in Presence of Notary)**

   **Signature:**

   **(Notary)**

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**A. Medical Exemption:** By my signature below, I confirm that this child has a medical condition that requires an exemption to one or more vaccines.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Medical</th>
<th>Non-Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria, Tetanus, and Pertussis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**B. Non-Medical Exemption:** A child is not required to have an immunization that is being administrated. Please check the appropriate box.

- Measles, Mumps, Rubella
- Polio
- Diphtheria, Tetanus, and Pertussis

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**Section 2:** Verify history of varicella disease, and section 3 to consent to share immunization information.
ST. CLOUD AREA SCHOOL DISTRICT 742 ANNUAL PHYSICAL FORM

If you child needs a sports physical, please use the Minnesota State High School League document or have your healthcare provider print the clinic’s sports physical document. Return sports physicals to the school nurse.

Name ___________________________ Male ___________ Female ___________ Birthdate ___________________________
Address ____________________________________________________________ Phone ___________________________
Parent/Guardian ___________________________ Physician/Healthcare Provider ___________________________
Last physical exam ___________________________ Dentist ___________________________ Last dental exam ___________________________

Significant Past History

YEAR | YEAR
--- | ---
Allergy (specify) | Mental Health Condition (specify)
Asthma | Neurologic (specify)
Chicken Pox (Disease) | Orthopedic (specify)
Congenital Defect (specify) | Seizure History
Developmental Delay | Surgeries (specify)
| T&A
| Myringotomy tubes, Hernia
Diabetes | Vision: Glasses or Contacts
Hearing | Other
Heart Condition __________________________________________________________

Health Examination

(To be completed by Physician/Healthcare Provider)

Examing Physician’s/Healthcare Provider’s Name (Print) ___________________________

Ht. _______ Wt. _______ BMI _______ Pulse _______ BP _______ Urinalysis _______ HGB _______
Orthopedic/Scoliosis __________________________________________________________
Skin __________________________________________________________
Allergies (if so, what?) ______________________________________________________
Nutrition __________________________________________________________
Serious Illnesses __________________________________________________________

Please review immunizations and update for school requirements as needed. Please attach copy of immunization record.

Does student require medication on a daily or episodic routine?

Name of medication: ___________________________

Dose: ___________________________ Frequency: ___________________________

Condition being treated: ___________________________

*Please include a separate physician/healthcare provider's order if medication will be taken at school.

Significant Development History __________________________________________________________

History of: Hearing Problem ___________________________ Speech Problem ___________________________
History of: Social or Emotional Problem ___________________________

List conditions which may limit participation in:

A. Classroom Activity __________________________________________________________
B. Physical Education __________________________________________________________
C. Competitive Sports __________________________________________________________

***If child is participating in sports, please complete MSHL sports physical form or provide clinic generated document.

Any special health problems, recommendations and/or comments ___________________________

Immunization(s) given today __________________________________________________________

Approved for: Full Activity ___________________________ Limited Activity ___________________________

Date ___________________________ Examining Physician/Healthcare Provider Signature ___________________________

I hereby release this information to the Health Services Department of District 742 and give the licensed school nurse permission to clarify the information with the Physician/Healthcare Provider if the need arises.

______________________________
PARENT/GUARDIAN SIGNATURE

NS16.25, Revised 2/4/22